United States Virgin Islands Central Cancer Registry
Hospice & Nursing Homes' Cancer Report Form*

Hospice Care Facility Information	
Facility Name	Phone Number
Address	
Patient transferred/referred from/by	

Patient's Information			
Last Name	First Name	Middle Name	
Address (please include Estate, City, State, Zip)			
Social Security	Date of Birth	Medical Record #	Health Insurance
Marital Status	Sex: ⊙ Male ○ Female ○ Other: _____		

Cancer Information		
Date Diagnosed (mm/dd/yyyy):	Where diagnosed?	
Primary Site (e.g.: colon, breast, prostate, etc)	Histology (adenocarcinoma, sarcoma, squamous carcinoma)	

Treatment Information			
	Type / Description	Date	Where performed
Surgery			
Radiation			
Chemotherapy			
Hormone			
BRM			
Other			

Comments

Follow Up / Patient Status	Completed by
Date of last contact: Vital Status: ⊙ Alive ○ Dead Cancer Status: ○ evidence of CA ○ no evidence of CA If expired; please provide date and place of death:	Name: Date:

This form is intended for hospice care setting ONLY. Not for physicians, hospitals or healthcare clinics.

*****Please, send the completed form to the USVI-CCR via e-mail to: xxx@doh.vi.gov***

In order to protect our patient's privacy and to comply with HIPAA regulations the attached forms must be encrypted and password protected using an encryption software. Microsoft encryption is not recommended.

HOSPICE'S CANCER REPORT FORM INSTRUCTIONS

Facility Information	
Reporting Facility	Record the complete name, address, and telephone number of your facility or physician's office.
Patient transferred / referred from/by	Record the facility information that referred the patient to your institution

Patient Information	
Patient Name (Last, First & Middle)	Record the patient's full name.
Patient's Address	Record patient's permanent home address at time of diagnosis, not a temporary relocation for treatment. Street address takes priority over post office box number.
Social Security Number	Record the patient's social security number. Do not record a spouse's number.
Date of Birth	Record patient's birth date in MM/DD/YYYY format.
Medical Record Number	Record the patient's medical record number
Health Insurance	Record the patient's health insurance
Marital status	Specify patient's marital status at time of diagnosis
Sex	Check off the patient's sex/gender.

Cancer Information	
Date of Diagnosis	Record the date the patient was first diagnosed with cancer by a recognized medical practitioner. Record in MM/DD/YYYY format. If unknown, record "unk".
Where Diagnosed?	If the patient was diagnosed elsewhere, record the facility name and location. If unknown, record "unk".
Primary Site	Record the site of origin of the tumor. Record the subsite if known (ie. UOQ breast, LL lung). If unknown, record "unk". It is important to identify the primary site and not a metastatic site.
Histology	Record the histologic cell type of the tumor (ie. mucinous adenocarcinoma; infiltrating ductal CA

Treatment Information	
Treatment	Record all first course treatment that the patient received. Do not record second course treatment. First course treatment includes all cancer-directed treatment modalities given by clinicians at the time of diagnosis. When recording treatment, write the type of treatment, the date the treatment was received or began and where performed.

Follow Up / Patient Status	
Date Last Seen	Record the date the patient was last seen or date of death in MM/DD/YYYY format.
Vital Status	Check the vital status of the patient as of the date last seen.
Cancer Status	Check the patient's cancer status as of the date the patient was last known to be alive or dead..
If Expired, Place of Death	If patient expired, record the place of death. If unknown, record "unk".
Cause of Death	If patient expired, record the cause of death. If unknown, record "unk".

Completed by	
Form Completed By	Record the full name of the person completing the form.
Date Completed	Record the date completed.